

State of California
Department of Health Services



GRAY DAVIS
Governor

June 13, 2002

CHDP Program Letter No. 02-05

TO: ALL COUNTY CHILD HEALTH AND DISABILITY PREVENTION (CHDP)
PROGRAM DIRECTORS, DEPUTY DIRECTORS, MEDICAL
CONSULTANTS, STATE CHILDREN'S MEDICAL SERVICES (CMS)
BRANCH STAFF AND REGIONAL OFFICE STAFF

SUBJECT: PROVIDER RATE INCREASE FOR COUNTY AND COMMUNITY
OUTPATIENT CLINICS

The purpose of this CHDP Program Letter is to inform you that the Orthopedic Hospital Association v. Belshe, San Bernardino County, et al. v. Department of Health Services (DHS), and Barlow Respiratory Hospital, et al. v. DHS lawsuit has been settled effective April 16, 2002. The lawsuit pertains to specific providers who will be eligible to be paid at a higher rate for CHDP health assessments provided to Medi-Cal beneficiaries. The effective date of the rate increase begins with dates of service on or after July 1, 2001.

The rate increase applies to CHDP services provided by county hospital outpatient clinics (CHDP provider type 01) and community hospital outpatient clinics (CHDP provider type 02) only. As a result of the settlement, the reimbursement is approximately 30 percent greater than the current reimbursement rates for CHDP services as of June 30, 2001. This rate increase applies only to CHDP service codes, which were in effect as of June 30, 2001 (e.g., CHDP Codes 23, 24, and 67 do not qualify for the rate increase as they were not in effect on June 30, 2001). Subsequent rate adjustments will be applied automatically on an annual basis through June 30, 2005. However, any other prospective reimbursement rate increases for providing care to Medi-Cal beneficiaries through June 30, 2005, will not be applied to CHDP services delivered by provider types 01 and 02.

Criteria for processing the PM 160s to determine the rate of payment for dates of service on or after July 1, 2001, will be as follows:

- Claims paid prior to May 20, 2002, will be reprocessed to pay the adjustment between the CHDP base rate and increased rate. (Providers will not have to resubmit any documentation.)



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- Claims in process and ready for payment between May 20, 2002, and June 13, 2002, will have the additional rate automatically applied to the CHDP base rate.
- Claims processed for payment after June 13, 2002, will be paid based on the fee billed on the PM 160, not to exceed the increased rate. The provider will need to review the Remittance Advice Detail to determine if the rate they were paid is lower than the new increased rate. If the provider is reimbursed at less than the increased rate, they will need to submit a new PM 160 using the "Balance Due Process" (see CHDP Provider Manual, Section 511) to receive the increase.

We have instructed providers to bill their usual and customary fees, which will enable them to receive the increased rates when the adjustments are applied in subsequent years.

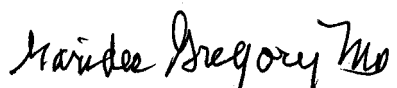
Enclosed are tables reflecting the current reimbursement rates for CHDP services for non-Medi-Cal clients (200 percent of the federal poverty level) and the current reimbursement rates for CHDP services from July 1, 2001, through June 30, 2002, for Medi-Cal clients for provider types 01 and 02 only. The rate increases for subsequent years for Medi-Cal clients are as follows:

July 1, 2002 – June 30, 2003 – 1.3433 x CHDP base

July 1, 2003 – June 30, 2004 – 1.3881 x CHDP base

July 1, 2004 – June 30, 2005 – 1.4344 x CHDP base

Please do not forward this Program Letter to your provider network. CHDP provider types 01 and 02 have received notification of the settlement with instructions regarding billing. Copies of the letters for providers in your jurisdiction will be forwarded to you. If you have any questions, please contact Ken Leach, at (916) 322-8725.



Maridee A. Gregory, M.D., Chief
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Enclosures

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CHDP VACCINE BENEFIT AND REIMBURSEMENT TABLE FOR PROVIDER TYPES 01 AND 02*

VACCINE	VACCINE SOURCE	PM 160 CODE	AGE RANGE	NON-MEDI-CAL RATE ¹	MEDI-CAL-RATE 7/01/01-6/30/02	COMMENT REQUIRED
DTaP	VFC	45	2 months through 6 years, 11 months	\$9.00	\$11.70	
DT Pediatric	Purchased	59	2 months through 6 years, 11 months	\$10.93	\$14.21	
Td Adult	Purchased	60	7 years through 20 years, 11 months	\$10.93	\$14.21	
Hepatitis A	VFC	65	2 years through 18 years, 11 months	\$9.00	\$11.70	
	(Pediatric)					
	Purchased	66	19 years through 20 years, 11 months	\$65.48	\$85.12	
	(Adult)					
HBIG ²	Purchased	41 + 57	newborn through 20 years, 11 months	\$168.12	\$218.56	Reason for administration
Hepatitis B/ Hib Combination	VFC	56	2 months through 4 years, 11 months	\$9.00	\$11.70	
Hepatitis B Lower Dose (Pediatric/Adolescent)	VFC	40	newborn through 18 years, 11 months	\$9.00	\$11.70	
Hepatitis B Higher Dose (Adult)	VFC	42	11 years through 15 years, 11 months ³	\$9.00	\$11.70	(Use this code for 2 dose adolescent schedule)
Hepatitis B	Purchased	51	19 years through 20 years, 11 months	\$38.17	\$49.62	
Hib	VFC	38	2 years through 18 years, 11 months	\$9.00	\$11.70	High risk factor, if older than 5 years
	Purchased	63	19 years through 20 years, 11 months	\$16.82	\$21.87	High risk factor
Influenza	VFC	53	6 months through 18 years, 11 months	\$9.00	\$11.70	High risk factor
	Purchased	54	6 months through 20 years, 11 months	\$13.76	\$17.89	High risk factor
MMR	VFC	33	12 months through 18 years, 11 months	\$9.00	\$11.70	
	Purchased	48	19 years through 20 years, 11 months	\$38.27	\$49.75	
Measles ⁴	Purchased	34	12 months through 20 years, 11 months ⁵	\$21.29	\$27.68	Reason for administration

*Provider Type 01 - County Hospital Outpatient Clinic

Provider Type 02 - Community Hospital Outpatient Clinic

CHDP VACCINE BENEFIT AND REIMBURSEMENT TABLE FOR PROVIDER TYPES 01 AND 02*

VACCINE	VACCINE SOURCE	PM 160 CODE	AGE RANGE	NON-MEDI-CAL RATE ¹	MEDI-CAL-RATE 7/01/01-6/30/02	COMMENT REQUIRED
Polio-Inactivated	VFC	39	2 months through 18 years, 11 months	\$9.00	\$11.70	
	Purchased	64	19 years through 20 years, 11 months	\$29.84	\$38.79	High risk factor
Pneumococcal Polysaccharide (23PS)	Purchased	55	2 years through 20 years, 11 months	\$20.74	\$26.96	High risk factor
Pneumococcal,hepta-valent (Prevnar)	VFC	67	1 month through 4 years, 11 months	\$9.00	\$9.00	
Rubella ⁶	Purchased	36	12 months through 20 years, 11 months	\$24.50	\$31.85	Reason for administration
Varicella	VFC	46	12 months through 18 years, 11 months ⁷	\$9.00	\$11.70	
	Purchased	52	19 years through 20 years, 11 months	\$48.94	\$63.62	Includes those born before 1/1/83, not VFC
1. Total reimbursement, includes administration fee.						
2. Only for infants with HBsAg (+) mothers and for children exposed to known/suspected HBsAg (+) blood /tissue fluids.						
3. Adolescent two dose immunization schedule, currently approved for age 11 years through 15 years, 11 months.						
4. For individuals with a contraindication to rubella or mumps vaccine.						
5. Measles vaccine (or, if not available, MMR) is recommended in children as young as 6 months, in outbreak situations.						
6. For individuals with a contraindication to measles or mumps vaccine.						
7. Youth with date of birth before 1/1/83 must be in close contact with persons at high risk of complications from varicella.						

*Provider Type 01 - County Hospital Outpatient Clinic
 Provider Type 02 - Community Hospital Outpatient Clinic

CHDP LABORATORY BENEFIT AND REIMBURSEMENT TABLE

PROVIDER TYPES 01 AND 02*

LABORATORY BENEFIT	CHDP CODE ^a	Non-Medi-Cal Rate	Medi-Cal Rate 7/1/2001- 6/30/02
Hemoglobin or Hematocrit	8	\$3.01 ^b	\$3.91 ^b
Urine "Dipstick"	9	\$2.87	\$3.73
Urinalysis, routine, complete	10	\$4.54	\$5.90
Hemoglobin Electrophoresis	13	\$30.11 ^b	\$39.14 ^b
Lead: Blood Lead Level Types	15	\$22.45 ^{b/c}	\$29.19 ^{b/c}
VDRL, RPR or ART	16	\$4.56 ^b	\$5.93 ^b
Gonorrhea (GC) Test	17	\$6.02 ^b	\$7.83 ^b
		d	d
Pap Smear	18	\$11.22 ^d	\$14.58 ^d
Chlamydia Test	20	\$19.25 ^e	\$25.03 ^e
Pelvic Exam	21	\$10.50 ^d	\$13.65 ^d
Ova and/or Parasites	22	\$11.90	\$15.47
Lead Test - Lead counseling and blood drawing for lead testing	23	\$18.73 ^f	\$18.73 ^f
Lead Refer - Counseling and referral for blood drawing for lead testing	24	\$0.00 ^f	\$0.00 ^f
Collection and Handling Fee		\$4.86	\$6.32
a. Available for CHDP Eligible, regardless of age, when either to comply with periodicity requirements or when determined to be medically necessary			
b. Collection and handling fee is allowable.			
c. Code 15 (use only by Clinical Lead Laboratory or Clinical Laboratory Providers)			
d. Collection and handling fee is included in "Pelvic Exam" fee for test codes 18 and 20 for females.			
e. Collection and handling fee is allowed for test code 20 when the patient is a male or when the patient is a female and a pelvic exam is not being claimed.			
f. (Use by all providers other than Clinical Lead Laboratory or Clinical Laboratory Providers)			

*Provider Type 01 - County Hospital Outpatient Clinic
 Provider Type 02 - Community Hospital Outpatient Clinic

**REIMBURSEMENT RATES
FOR
HEALTH SCREENING PROCEDURES**

PROVIDER TYPES 01 AND 02*

CHDP CODE	Description	Visit Type	Age	Non-Medi-Cal Rate	Medi-Cal Rate 7/1/2001- 6/30/02
01	History/Physical	New/Extended	12-20/11yrs	\$62.39	\$81.11
	Comprehensive	Routine	12-20/11yrs	\$49.90	\$64.87
		New/Extended	5-11/11 yrs	\$54.59	\$70.97
		Routine	5-11/11 yrs	\$42.12	\$54.76
		New/Extended	1-4/11 yrs	\$51.46	\$66.90
		Routine	1-4/11 yrs	\$39.00	\$50.70
		New/Extended	0-0/11 yrs	\$48.35	\$62.86
		Routine	0-0/11 yrs	\$35.86	\$46.62
	Health Assessment	New/Extended	12-20/11 yrs	\$54.59	\$70.97
	Only	Routine	12-20/11 yrs	\$46.79	\$60.83
		New/Extended	5-11/11yrs	\$46.79	\$60.83
		Routine	5-11/11yrs	\$39.00	\$50.70
		New/Extended	1-4/11 yrs	\$43.66	\$56.76
		Routine	1-4/11 yrs	\$35.86	\$46.62
		New/Extended	0-0/11 yrs	\$40.55	\$52.72
		Routine	0-0/11 yrs	\$32.75	\$42.58
06	Snellen Eye Test, 7 years and older			\$2.54	\$3.30
	Snellen Eye Test, 3- 6 years			\$5.04	\$6.55
07	Hearing, Audiometric			\$11.60	\$15.08
12	TB Mantoux Test			\$7.91	\$10.28
21	Pelvic Exam			\$10.50a	\$13.65a
	Collection and Handling Fee			\$4.86	\$6.32
a. Collection and handling fee is included in "Pelvic Exam" fee for test codes 18 (Pap Smear) and 20 (Chlamydia Test) for females. See CHDP Laboratory and Reimbursement Table.					

*Provider Type 01 - County Hospital Outpatient Clinic
 Provider Type 02 - Community Hospital Outpatient Clinic